



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

EDWIN E JOHNSTONE MD PA
2323 SO SHEPHERD DR SUITE 908
HOUSTON TX 77019

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

ULLICO CASUALTY CO

Carrier's Austin Representative Box

Box Number 48

MFDR Tracking Number

M4-11-1792-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "not paid ignored"

Amount in Dispute: \$750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A position summary was not included in the carrier response.

Response submitted by: Emerald Claims Management; 21977 E Wallis Dr.; Porter TX 77365

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 17, 2010	99205 99354	\$750.00	\$143.49

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets forth the medical fee guideline for professional services.
3. The respondent submitted a copy of a check payment issued March 14, 2011. The requestor was advised of the payment; however, the requestor stated a balance remains.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated March 3, 2011

- W1 – Workers Compensation State Fee Schedule Adjustment
- 18 – Duplicate claim/service

Explanation of benefits dated March 14, 2011

- 100 – An office visit was already billed on this date
- 222 – Charge exceeds fee schedule allowance
- 18 - Duplicate claim/service
- W1 – Workers Compensation State Fee Schedule Adjustment

Issues

1. Did the requestor bill appropriately for CPT code 99354?
2. Did the respondent reimburse CPT code 99205 according to the medical fee guideline and is reimbursement due for CPT code 99354?

Findings

1. The respondent submitted an explanation of benefits dated March 14, 2011, with its response; however, it included CPT code 99344. The requestor's Table of Disputed Services and medical billing indicate CPT code 99354 was billed. The respondent's response includes a copy of a bill with CPT code 99354 that was received by Gallagher Bassett on February 18, 2011. Neither party submitted an explanation of benefits for CPT code 99354.

The description of CPT code 99354 is as follows: Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour (List separately in addition to code for other outpatient Evaluation and Management service). The evaluation and management report submitted with this dispute is reviewed. Documentation supports this prolonged billing.

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

28 Texas Administrative Code §134.203(b) (1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

2. 28 Texas Administrative Code §134.203(c) (1) (2) states, "To determine the maximum allowable reimbursement (MAR) for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor is to be applied. The conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. Commissioner's Bulletin # B-0048-09 states for services provided in calendar year 2010, the Medical Fee Guideline conversion factors in rule §134.203(c) are \$54.32 and \$68.19. The conversion factor of \$54.32 applies to service categories of Evaluation and Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting.

The MAR for 99205 is $\$54.32 \div 36.8729 \times \$198.68 = \$292.69$. The respondent paid \$292.69. No additional reimbursement is recommended.

The MAR for 99354 is $\$54.32 \div 36.8729 \times \$97.40 = \$143.49$. The respondent paid \$0.00. Recommend reimbursement of \$143.49.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$143.49.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$143.49 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	_____
Signature	Medical Fee Dispute Resolution Officer	Date

MAY 15, 2012

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.